Los Angeles County Department of Mental Health
Office of the Medical Director

Pharmacy Services
550 South Vermont Avenue
Los Angeles, CA 90020
Phone: (213) 738-4725

Fax to Pharmacy Services: (213) 637-2550

Medication Treatment Authorization Request (M-TAR)

Client Information	Name:		MIS #:	Date of Birth:	Gender:	Date Requested:
	Requested Medication and Strength:					☐ Initial ☐ Continued
	Primary Diagnosis/Relevant Medical Condition(s)/Substance Use Disorder(s)					

Medication-Specific Criteria (Note: Check boxes under specific medication to attest that *all* criteria is met for that medication)

Psychostimulants

☐ Client is over the age of 16 and has been prescribed psychostimulants by a DMH prescriber (directly-operated or contracted site) continuously for at least one year prior to the request.

Zolpidem *(and other off-formulary insomnia medications)*

☐ Client is not currently prescribed or receiving benzodiazepine.

☐ Client does not have current substance use diagnosis.

☐ If client is currently using requested medication, length of time from first prescription is less than six months.

Anticraving medications (Acamprosate, Naltrexone ER, Varenicline, Buprenorphine)

☐ Client has substance use disorder with significant impairment.

☐ Client is receiving ongoing substance abuse counseling.

☐ Clinical record documents evidence of effectiveness after 3 months use.

Gabapentin

☐ Prescriber has indicated in clinical record awareness that there is currently no FDA indication for gabapentin for a mental health disorder.

☐ Prescriber has documented in the clinical record an explanation of the clinical decision-making and awareness of practice outside of DMH parameters.

Branded Antipsychotic Polypharmacy *(Please note current and past medications in Rationale Section)*

☐ Client/Medication not eligible for Indigent Medications Program.

☐ Monotherapy or alternative polypharmacy (use of more than 1 branded antipsychotic) would cause significant adverse effects and/or poor outcomes.

☐ Client had an unfavorable response to the current medication that requires an immediate switch.

Please indicate one:

☐ Switch

☐ Ongoing Polypharmacy

☐ Transfer of Care (e.g. hospital discharge)

Rationale (For any medication listed above, include additional information related to request.)
(For any medication not listed above, describe complete clinical rationale for request and attach additional documentation if necessary)

Prescriber/Furnisher Information (*I hereby state that all of the indicated conditions pertain and the documented reasons for these conditions are accurate.*)

Name:	Signature:	Supervising Psychiatrist Name*:	Signature:
DMH Site/Clinic Name:	Phone #:		**FAX # (REQUIRED):**

DMH Action (For DMH Pharmacy Services Use Only)	Reviewing Pharmacist Name:	Reviewing Pharmacist Signature:	Date:
	☐ Accept ☐ Deny	Reason:	
	Duration (in months):**		Drug Code:

*Designees must include name of Supervising Psychiatrist and Designee name and signature. No Supervising Psychiatrist signature is required if the site is a DMH Contractor (i.e. not directly-operated).
**Duration can be approved for up to 6 months. The exception is Zolpidem (and other off-formulary insomnia medications) for which the maximum is 30 days.

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